



460 Totten Pond Road, Suite 690
Waltham, MA 02451

June 23, 2008

Ms. Katharine London
Executive Director
Health Care Quality and Cost Council
(via e-mail)

Dear Ms. London:

I am pleased to present comments on regulation 129 CMR 3.00: Disclosure of Health Care Claims Data, on behalf of the Massachusetts Health Data Consortium. Please note that these comments represent the views of the Consortium staff, and may not necessarily represent the views of all of our Board members.

We commend the Health Care Quality and Cost Council for its efforts to publish quality and cost data based on the all-payer claims database that the Council is establishing. We believe that transparency is a critical value, and that making quality and cost data available will improve quality of care and enhance the value of healthcare services purchased by payers and received by patients.

The Consortium is exceedingly familiar with the challenge of balancing transparency of data with the need to protect patient confidentiality of highly personal and often sensitive healthcare data. We recognize that the Council takes very seriously the obligation to effectively achieve this balance.

We are compelled to submit written testimony, however, because we do not believe that all perspectives on this issue were represented during the public hearing that was held on June 11, 2008. In particular, the needs and desires of health services researchers and employers did not seem to be aired during the public hearing.

Timing: In order for data to be clinically relevant to clinicians, it must not only be accurate and statistically valid, but must be timely. Data that is 18-24 months old will not be seen as clinically relevant. Therefore, it is essential that the Data Release Review Board have as streamlined and expedited a review process as possible. The 45-day review period seems appropriate, as long as the Review Board meets on a frequent basis. If the Review Board meets less frequently than quarterly, it will reduce the effectiveness

and the impact of data for quality improvement, research projects, and employer analyses of cost, quality, and utilization.

Restricted data: Our understanding is that the proposed regulation is more restrictive regarding the data elements that are unrestricted, restricted, or not for release than the rules that other states have adopted. Specifically, we would recommend that the following data elements should be re-classified as indicated below:

- ME001 Payer should be unrestricted.
- ME002 National Plan ID should be unrestricted.
- ME009 Plan Specific Contract Number should be unrestricted.
- ME014 Member Age in Years should be unrestricted.
- MC001 Payer should be unrestricted.
- MC002 National Plan ID should be unrestricted.
- MC008 Plan Specific Contract Number should be unrestricted.
- MC015 Member State should be unrestricted.
- MC023 Member Age in Years at Discharge should be unrestricted.
- MC024 Service Provider Number should be unrestricted.
- MC025 Service Provider Tax ID Number should be unrestricted.
- MC026 National Service Provider ID should be unrestricted.
- MC032 Service Provider Specialty should be unrestricted.
- MC062 Charge Amount should be unrestricted.
- MC063 Paid Amount should be unrestricted.
- MC064 Prepaid Amount should be unrestricted.

A similar request for re-classification applies to the Pharmacy Claims Data Release data elements.

We would also suggest changes in the regulatory language that would encourage broader use of the all-payer claims dataset for public purposes. The specific changes we request are:

- 3.03(2)(b)1: “project description” implies that there is a specific – and perhaps time-limited – research project to be completed. We believe that there are other public uses that might not be project-related (e.g., an employer or health plan might want to review the data on an annual basis).
- 3.03(2)(c)5: We do not believe that it is necessary to “ensure that the identities of clinicians will be kept confidential”; in fact, we think that it is in the public interest to make this information widely available.
- 3.03(2)(c)6 and 3.04(2): Similarly, we believe that it is in the public’s interest to publish individual payment rates.

Transparency: While we are enthusiastic that the Council is creating a public Website with cost and quality data, “transparency” does not mean merely having a Website. True

transparency requires making the data available to researchers, providers, purchasers, and consumer advocates so that these organizations may perform their own analyses.

Consulting function: Our final comment is regarding the ability of other organizations to obtain the Council's all-payer claims database. Having the Massachusetts Health Data Consortium as a neutral holder of the hospital discharge dataset has been a community benefit for the past 30 years. Our ability to provide the database, off-the-shelf reports, and customized reports is a valuable service for community hospitals, nursing homes, and other relatively small providers who do not have analytics staff nor can afford purchasing these products from commercial data vendors. We strongly encourage the Council to make the claims dataset available to organizations like ours so that data analytics may be available to physician offices, community hospitals, and other interested parties.

Thank you for your consideration of our comments. Please let me know if you have any questions or would like to discuss these comments.

Sincerely yours,

/ s /

Ray A. Campbell III
CEO and Executive Director